



Immunization Program

2011 Provider Profile (Birthing Hospital) Vaccines for Children Program

All State-approved public and private health care providers participating in the Vaccines for Children (VFC) program must complete this form. This document provides shipping information and helps the State determine the amount of vaccine supplied through the VFC program. This form also may be used to compare estimated vaccine needs with actual vaccine supply. The Montana Immunization Program must keep this record on file with the "Provider Agreement" form. This form must be updated annually or more frequently if 1) the number of children being served changes or 2) the status of the facility changes (e.g., private provider becomes an agent of a Federally Qualified Health Center).

1. Today's date _____
2. Provider's Name: _____
3. Hospital Name: _____
4. Vaccine Delivery Address: _____
(if receiving direct vaccine shipments) Street (No P.O. Boxes)

City State Zip

Mailing Address: _____
(if different from above) Address

City State Zip
5. Days and Times Vaccine May be Delivered: _____
6. Contact Person: _____
Last First

Email Address

Title
7. Telephone Number: () _____
8. Fax Number: () _____

Hospital Name _____

2011 Provider Profile (Birthing Hospital) Continued

9. Type of Facility:

- | | |
|---|---|
| <input type="checkbox"/> Public Health Department | <input type="checkbox"/> Federally Qualified Health Center (FQHC) |
| <input type="checkbox"/> Public Hospital | <input type="checkbox"/> Federally Designated Rural Health Clinic (RHC) |
| <input type="checkbox"/> Private Practice (Individual or Group) | <input type="checkbox"/> Other Public Facility _____ |
| <input type="checkbox"/> Private Hospital | <input type="checkbox"/> Other Private Facility _____ |

10. Patient Population:

Note: The following information must be based on data and not estimated.

Part A. Count the number of infants receiving the hepatitis B birth dose at your health facility (include VFC and non-VFC-eligible children.)

	<1 Year Old
Total # Immunized Children	

Part B. Of the total number entered above, how many infants are VFC eligible and non-VFC eligible, by category.

	<1 Year Old
Enrolled in Medicaid (VFC)	
No health insurance (VFC)	
American Indian/Alaska Native (VFC)	
Insured (non-VFC)	

Method used to calculate profile numbers: (check all that apply)

- ☐ VFC Vaccine Eligibility Form
- ☐ WIZRD
- ☐ Facility computer report
- ☐ Other _____